STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#1	445075	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #46397, #46435, and #46558 were completed on 1/15/19 at Signature Healthcare of Madison. Deficiencies were cited related to the recertification survey and complaint investigation #46397 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	**F623** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Residents #9, #11, #22, and #30 had no negative outcome from not notifying the hospital or ombudsman of transfer or discharge How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit for like residents who have had a transfer/discharge for the month of January was completed by the Social Services Director on 1/16/2019, and the Ombudsman was made aware via Fax. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/15/2019, the social worker was inserviced by the Administrator on the company *Transfer/Discharge Notice* Policy. Beginning on 1/16/2019 and ongoing, the Social Service director to notify the Ombudsman by the twentieth of every month of transfers/discharges from the facility for the previous month via Fax utilizing the Discharge and Transfer Form Ombudsman Fax Log, and to bring the log and fax notification to the monthly QAPI meeting for review.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-, (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 2/2/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623	Continued From page 1 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 623	How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of discharge or transfer of residents will be reviewed and discussed monthly x2 months by the QAPI committee to ensure timely notification to the Ombudsman. The results of these audits will be carried through the monthly Quality Assurance Process Improvement ("QAPI") meeting for follow up and discussion. At that time, QAPI committee will determine compliance and future audit monitoring if indicated.	2.7.19

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F 623	Continued From page 2 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to send notification of transfer to the hospital to the Ombudsman for 4 residents (#9, #11,#22, and #30) of 39 residents reviewed. The findings include: Review of the facility policy, Transfer/Discharge Notice, dated 12/6/16 revealed "...The facility will send a copy of the transfer or discharge notice to	F 623		

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F 623	Continued From page 3 a representative of the Office of the State Long-Term Care Ombudsman..." Medical record review revealed Resident #9 was admitted to the facility on 1/19/15 with diagnoses included Paralytic Syndrome, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, Paraplegia, Personality Disorder, Altered Mental Status, Major Depressive Disorder, and Panic Disorder. Medical record review of the Discharge Minimum Data Set (MDS) dated 11/24/18 revealed Resident #9 was transferred to the hospital. Medical record review revealed Resident #11 was admitted to the facility on 3/7/17 with diagnoses included Schizoaffective Disorder, COPD, Hypertension, Diabetes, and Seizure Disorder. Medical record review of the Nursing Home To Hospital Transfer Form revealed Resident #11 was transferred to the hospital on 9/19/18. Medical record review revealed Resident #22 was admitted to the facility on 4/24/18 with diagnoses included, COPD, Hypertension, and Cerebral Infarction. Medical record review of the Nursing Home To Hospital Transfer Form revealed Resident #22 was transferred to the hospital on 10/14/18. Medical record review revealed Resident #30 was admitted to the facility on 8/21/13 with diagnoses included Paralytic Syndrome, Encephalitis, and Encephalomyelitis. Medical record review of the Nursing Home To	F 623		

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F 623	Continued From page 4 Hospital Transfer Form revealed Resident #30 was transferred to the hospital on 12/18/18. Interview with the Social Worker on 1/15/19 at 1:50 PM in her office revealed she did not know she had to contact the Ombudsman when a resident was transferred or discharged from the facility. Further interview revealed the transfer and discharge notification to the Ombudsman had not been done since October 2018. Interview with the Administrator and Director of Nursing (DON) on 1/15/19 at 1:57 PM in the Administrator's office confirmed the facility had not notified the Ombudsman when a resident transferred or discharged from the facility. Further interview with the DON revealed "...nobody is doing it right now, it is on the list..." Further interview with the Administrator stated "...the one person responsible [to notify the Ombudsman of resident transfer or discharge] would have been the social worker..."	F 623		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690	**F690** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #25 received a thorough investigation completed on 12/5/2018 with the attempt to insert a Foley catheter without an order. Resident suffered no negative impact from isolated occurrence.	

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F 690	Continued From page 5 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to obtain physician orders for placement of an intermittent catheter for 1 resident (#25) of 39 residents reviewed. The findings include: Review of the undated facility policy, Physician Orders, revealed "...orders given by Physician/Medical Practitioner...notification to family/POA [Power of Attorney] via telephone...New order documented in nursing notes that order was received and family notified..."	F 690	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? There are currently no like residents in the facility, as this was an isolated incident deemed by a thorough facility investigation on 12/5/2018. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? Beginning on 1/15/2019, the SDC or designee, will provide licensed nurses a copy of F-Tag *690 Bowel/Bladder incontinence, catheter* guidance during orientation and will highlight and review the areas of importance related to this citation. Beginning on 1/15/2019, current licensed nurses will be inservised on company *Physician Orders* policy by the SDC and/or designee. Beginning on 1/21/2019, the DON and/or designee will interview 3 residents a week for 4 weeks for possible placement of an intermittent catheter, and if indicated validate appropriate orders were obtained.	

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F 690	Continued From page 6 Medical record review revealed Resident #25 was admitted to the facility on 11/5/18 with diagnoses included Congestive Heart Failure, Urinary Tract Infection, Chronic Kidney Disease, and Lymphedema. Medical record review of Resident #25's Physician's Order Sheet revealed no order for intermittent catheter placement. Medical record review of an Admission Minimum Data Set (MDS) dated 11/12/18 revealed Resident #25 had a Brief Interview of Mental Status score of 15 indicating the resident was cognitively intact. Medical record review of Resident #25's Daily Skilled Nurse's Notes for 12/1/18 thru 12/10/18 revealed no documentation regarding an order for catheterization. Interview with Resident #25 on 1/13/19 at 9:24 AM in her room revealed she stated "The head nurse (the former Director of Nursing [DON]) came to help put a catheter in one evening, not sure if there was an order or not." Continued interview revealed she reports there were several people in the room trying to help place the catheter. She stated "the nurse, the one not here because she was fired, asked her if she could place the catheter to get a urine sample because she was sick." She stated "the nurse told me she was worried about me." "I told her she could go ahead and put the catheter in." Continued interview revealed she stated "I asked her if she had an order and she said yes." Interview with the Nurse Practitioner on 1/13/19 at 11:29 AM in the West dining room confirmed an	F 690	How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of system changes, education, and monitoring efforts will be conducted monthly x2 months by the QAPI committee to ensure facility has achieved substantial compliance. The QAPI committee will make any necessary changes to the system if indicated, and will determine compliance and any future audits or monitoring needed.	2.7.19

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F 690	Continued From page 7 order was not obtained for Resident #25 to be catheterized. Interview with Registered Nurse (RN) #4 on 1/14/19 at 3:49 PM at the North hall nursing station revealed she assisted the former DON in performing an intermittent catheterization for Resident #25. She stated the event happened in December 2018. Continued interview revealed she stated the former DON had told RN #4 that she had obtained an order for Resident #25 to be catheterized. She stated that she did not review Resident #25's record to ensure an order was obtained. Further interview revealed Resident #25 gave consent for the former DON to perform the catheterization. Interview with Licensed Practical Nurse (LPN) #2 on 1/14/19 at 4:06 PM at the South hall nurse station revealed she was asked by the former DON to assist in placing an intermittent catheter for Resident #25. She stated this happened sometime in December 2018. She stated there were 5 people including the former DON in the room with the resident. Continued interview revealed Resident #25 gave the former DON permission to place the catheter. She stated "I didn't know there wasn't an order for that until a few days later." She stated "the resident was fine; she never complained of anything, she didn't tell the former DON to stop." Interview with the Administrator and Director of Nursing on 1/15/19 at 2:43 PM in the Administrator's office confirmed an order was not obtained for the former DON to catheterize Resident #25. Continued interview revealed the former DON was suspended, terminated, and reported to the Tennessee Board of Nursing.	F 690		

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to obtain a physician order for oxygen for 1 resident (#108) of 4 residents receiving respiratory therapy. The findings include: Review of the facility policy, Physician Orders, reviewed 6/1/15, revealed an order given by the Physician/Medical Practitioner "...Nurse receiving order is responsible for complete order documentation..." Medical record review revealed Resident #108 was admitted to the facility on 12/28/18 with diagnoses include of Chronic Lymphedema, Morbid Obesity, Sleep Apnea, Hypoventilation Syndrome, Anxiety, and Chronic Obstructive Pulmonary Disease. Medical record review of the Admission Minimum Data Set dated 1/4/19 revealed Resident #108 had received oxygen while not a resident in the facility and received oxygen while a resident at the facility.	F 695	**F695** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #108 suffered no negative outcome from receiving oxygen as ordered from the hospital, or from not having the order transcribed onto the current month's orders. On 1/15/2019, the resident's clinical record was corrected. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 1/15/2019, Nursing Administration audited resident's clinical record who currently received oxygen to ensure appropriate orders are in place with no concerns identified.	

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F 695	Continued From page 9 Medical record review of the physician orders revealed no orders for oxygen administration. Observation on 1/13/19 at 8:50 AM, 11:25 AM, 11:45 AM, 11:56 AM, 2:47 PM, and 3:32 PM revealed Resident #108 was in the room, in bed, nasal cannula in use, and the oxygen concentrator in operation set at 2 liter per minute (lpm). Observation on 1/14/19 at various times during the day revealed Resident #108 in the room, in bed, nasal cannula in place, and oxygen concentrator set at 2 lpm. Observation on 1/15/19 at 10:13 AM in Resident #108's room, with the Director of Nursing (DON) present, revealed the resident in bed with the nasal cannula in place and the oxygen concentrator operating at 2 lpm. Interview with Certified Nurse Aide (CNA) #5 on 1/15/19 at 10:13 AM at the South nursing station revealed she had cared for Resident #108 since the resident's admission. When asked how long the resident had been using oxygen the CNA stated "...since admission..." Interview with the DON on 1/15/19 at 10:20 AM at the North/East nursing station confirmed Resident #108's admission orders and the 1/2019 recapitulation orders and phone orders did not have orders for oxygen. The DON confirmed the medical record for Resident #108 did not have oxygen orders. The DON stated she expected nurses to have orders for the oxygen. Interview with Licensed Practical Nurse (LPN) #2	F 695	What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? Beginning on 1/15/2019, each newly admitted resident's physician orders for oxygen and telephone orders for oxygen will be reviewed daily Monday - Friday in the clinical meeting by nursing administration to ensure proper transcription of orders to the EMAR and ETAR. Beginning on 1/15/2019, Licensed nursing staff will be educated on company *Physician Order Policy* by the SDC and/or designee, and ongoing during new-hire orientation. Beginning on 1/15/2019, the DON and/or designee will conduct random audits of Physician Orders for Oxygen 3x per week for 4 weeks to ensure proper transcription to the EMAR or ETAR. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the above system change, audits, and monitoring regarding Respiratory Care will be reviewed during the Quality Assurance Process Improvement meeting monthly x2 months for appropriate monitoring to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2.7.19

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F 695	Continued From page 10 on 1/15/19 at 10:30 AM by the South nursing station revealed the LPN had provided care since the day after Resident #108 was admitted. The LPN stated the resident had been on oxygen since the LPN had been providing the resident care. The LPN confirmed the medical record did not have an order for oxygen.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility staff failed to handle food in a sanitary manner when assisting residents with meals for 1 resident of 15 residents in the dining room. The facility dietary department failed to maintain dietary equipment in a sanitary manner; failed to maintain sanitizer in the sanitizer container used	F 812	**F812** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #5 had no negative outcome from having the roll handled by the staff member with bare hands. Corrective actions from kitchen observations are as follows: a) on 1/14/19 Ecolab rep revisited facility and properly recalibrated sanitizing systems to maintain proper range of parts per million (PPM), b) On 1/13/19, Plant Ops Director cleaned the condenser grate in the walk in refrigerator and Dietary Manager discarded of the eggs for possible contamination, c) Dry Storage Bins were wiped down and cleaned on 1/14/19 after the observation was voiced by health inspector, d) Range Top backsplash was cleaned and wiped down on 1/14/19 after observation was voiced by health inspector, e) Plant Ops Director drilled holes in the bottom of the ice scoop container on 1/14/19 allowing it to properly drain.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 to sanitize work surfaces; and failed to operate the dish machine with sanitizer in 1 of 6 observations of the dietary department. The findings include: Review of the facility policy, Assistance with Meals, revised 6/27/18 revealed, "...Employees who provide resident assistance with meals shall demonstrate competency in prevention of foodborne illness, including personal hygiene practices and safe food handling..." Medical record review revealed Resident #5 was admitted to the facility on 2/11/16 with diagnoses included Dementia with Behavioral Disturbances, Seizures, Alzheimer's Disease, Dysphagia, and Reduced Mobility. Medical record review of the Annual Minimum Data Set dated 1/2/19 revealed Resident #5 required total one person assist with eating. Observation on 1/13/19 at 12:15 PM in the East dining room at the noon meal revealed Registered Nurse (RN) #1 picked up a roll from Resident #5's plate with her bare hands and attempted to give Resident #5 a bite of the roll and also attempted to put the roll in the residents hand. Interview with RN #1 on 1/13/19 at 12:16 PM in the East dining room revealed, RN #1 stated "I have been feeding people like that for 30 years. I need to get a glove when handling residents food." Interview with the Director of Nursing on 1/14/19 at 8:50 AM in her office confirmed staff should	F 812	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were affected by the deficient practice of mishandling food item as this was an isolated observation. Due to sanitation observations in the kitchen, residents receiving a tray from the kitchen had the potential to be affected. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? Beginning on 1/13/2019, Nursing personnel, therapy, and activities staff will be inserviced on the Signature Healthcare *Assistance with Meals* policy, by the SDC and~~-~~or designee. Beginning on 1/21/19, Department heads will conduct random audits of meal service to ensure proper handling of food in a sanitary manner x4 weeks, addressing any observed concern immediately. Beginning on 1/21/19, a kitchen observation will be done weekly x4 weeks by the Administrator, or designee, to ensure areas of concern in the dietary department are appropriately cleaned and sanitized, and will immediately address any concerns. Beginning on 1/15/19, the Dietary Manager will ensure there is a 30 day audit of sanitizing system and will notate all PPM levels daily, and will contact Ecolab	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	01/15/2019

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F 812	Continued From page 12 never touch any resident's food with their bare hands. Observation on 1/13/19 at 9:02 AM in the dietary department walk-in refrigerator revealed a build-up of blackened debris and white debris on the condenser grate. Observation on 1/14/19 at 10:45 AM in the dietary department, with the Certified Dietary Manager (CDM) present, revealed the can opener blade tip and where the blade attached to the handle, had dried sticky blackened debris. Further observation of the can opener base slot revealed dried sticky blackened debris. Further observation of 3 storage bins containing flour, food thickening agent, and sugar revealed the lids had a heavy accumulation of dried food debris and multi colored dried splatters. The 3 bins exterior front and area in direct contact with the bin lid had a heavy accumulation of dried food debris and multi colored dried splatters. Further review of the range top back splash revealed a heavy accumulation of blackened debris. Further observation revealed 1 ice scoop stored in direct contact with the top of the ice machine. Observation of the other ice scoop revealed the scoop was stored in a container located on top of the ice machine. The container was on its side and the water draining could pool on the top of the ice machine. Interview with the CDM on 1/14/19 at 10:45 AM in the dietary department confirmed the dietary equipment was not maintained in a sanitary manner. Observation and interview on 1/14/19 at 2:10 PM in the dietary department, with the CDM present,	F 812	immediately if indicated. Beginning on 1/21/19, the Plant Ops Director will ensure the condenser grates are maintained and cleaned weekly x4 weeks, and moving forward, will add this observation to his weekly maintenance log. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the above system change audits and monitoring regarding food procurement/storage/prep/serve – sanitation will be reviewed during the Quality Assurance Process Improvement meeting monthly x2 months for appropriate monitoring to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2-7-19

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F 812	Continued From page 13 confirmed the walk-in refrigerator grate had an accumulation of blackened debris. Further interview confirmed the grate had an area on the lower right side with white debris. Further observation revealed fresh eggs stored in an egg crate were exposed and could possible have been contaminated. Observation on 1/14/19 at 1:30 PM in the dietary department revealed the CDM obtaining the sanitizer level of 2 sanitizer containers used to sanitize work surfaces. Further observation and interview with the CDM confirmed the sanitizer test strip failed to register the sanitizer level in 2 attempts. Further observation revealed the dish machine was in operation. The dietary staff operating the dish machine stated the dining room trays and 1 of 2 tray delivery carts contents had been processed through the dish machine. Further observation revealed the dietary staff member, with the CDM present, using a sanitizer test strip to determine the sanitizer level in the dish machine. Observation of 4 separate test strip attempts revealed no change in the test strip indicating no sanitizer in the dish machine. Interview with the dietary staff member revealed the dietary staff member failed to test the sanitizer level prior to starting the dish machine operation. Interview with the CDM confirmed the dish machine was in operation with no sanitizer.	F 812	**F919** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff	F 919	Resident's #37's call light was immediately replaced upon discovery of its absence on 1/13/19 by the Plant Operations Director. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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F 919	Continued From page 14 work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a call light for 1 resident (#37) of 59 residents. The findings include: Medical record review revealed Resident #37 was admitted to the facility on 9/4/18 with diagnoses included Cerebral Infarction, Aphasia, Dysphagia, Weakness, Diastolic (Congestive) Heart Failure, Acute Kidney Failure, Cerebral Aneurysm, Essential Hypertension and Delirium. Observation on 1/13/19 at 9:54 AM, 11:52 AM and 2:50 PM in Resident #37's room revealed no call light available for the resident. Interview with Registered Nurse (RN) #2 on 1/13/19 at 2:52 PM in Resident #37's room confirmed she did not have call light. Interview with the Director of Nursing (DON) on 1/13/19 at 9:01 AM in her office when questioned about who was responsible for ensuring residents have a call light, the DON stated, "...Everyone, anybody assigned to the room is..." The DON confirmed all residents should have a call light available.	F 919	On 1/13/2019, facility administration did a full audit of occupied beds and determined that no other resident was affected by the deficient practice. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? Facility system change is to conduct daily observation rounds utilizing the Plant Operations TELS system to log results beginning on 1/21/2019. Beginning on 1/15/2019, Facility nursing staff will be inserviced on the company *Call Light Policy* by the SDC and/or designee. Beginning on 1/21/2019, the Administrator, or designee, will conduct random audits of resident rooms for placement of call light 3x a week for 1 month. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the above system change audits and monitoring Call Light System will be reviewed during the Quality Assurance Process Improvement meeting monthly x2 months for appropriate monitoring to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2.7.19